MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

636

10493

CERTIFICATE OF DEATH

Reg. Diat. No. 356

1. PLACE OF DEATH:

County Worcester.

City or town Berlin R F D

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Worcester.

City or town Berlin R F D

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Sarah Elizabeth Adkins.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife George W. Adkins

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 4, 1871

8. AGE:	Years	Months	Days	If less than one day
	76	2	21	..... hrs. ..... min.

9. Birthplace Pittsville Wicomico Co. Md.
(Town, county, and state)

10. Usual occupation Housewife.

11. Industry or business

FATHER 12. Name John Burk Parsons.

13. Birthplace Md.

MOTHER 14. Maiden name Annie Parsons.

15. Birthplace Md.

16. Informant Mrs. Ruth Wyatt.

Address Berlin Md R F D 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/28/47 (month) (day) (year)

Cemetery or crematory New Hope.

Location Wellands Md.

18. Funeral director Anna A. Burbage

Address Berlin Md

19. 11-27 1947 (Date rec'd by registrar) Helen G. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 NW 1947 at 11:30 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1946, to 25 NW 1947

and that I last saw h.. alive on 25 NW 1947

Immediate cause of death	DURATION
Coronary Occlusion	30 minutes
Due to Coronary Sclerosis & Hypertension	1 year+
Due to	
Other conditions Toxic thyroid adenoma	2 years +

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Nathaniel L. Thomas M. D. or other

Address Ocean City Date signed 26 Nov 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

10493

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:

County: Worcester.

City or town: Berlin

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 80 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester.

City or town: Berlin R F D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Edward Jacob Aydelotte.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widower

6.(b) Name of husband or wife: Leah E. Aydelotte

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 22, 1866

8. AGE:	Years	Months	Days	If less than one day
	80	11	21	..... hrs. ..... min.

9. Birthplace: Berlin Wor. Co. Md.
(Town, county, and state)

10. Usual occupation: Farmer.

11. Industry or business

FATHER — 12. Name: Wm H. Aydelotte.

13. Birthplace: Md

MOTHER — 14. Maiden name: Mary E. Brittingham

15. Birthplace: Md

16. Informant: Mr. George Aydelotte.

Address: Berlin Md. R F D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/16/47 (month) (day) (year)

Cemetery or crematory: Evergreen.

Location: Berlin Md.

18. Funeral director: Anna P. Burbage

Address: Berlin Md

19. 11-16- 1947 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 13 1947 at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1, 1945 to Nov. 12 1947 and that I last saw him alive on Nov. 12 1947

Immediate cause of death	DURATION
Chronic Int. Nep.	
Due to Myocarditis	
Due to Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Clifford E. Catlett M. D. or other

Address: Berlin Md. Date signed .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

166

10494

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:
County: Worcester
City or town: Rural Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County: Accomack
City or town: Pungoteague
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War #2

3.(a) FULL NAME: Wilmer Raymond Clarke

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 10, 1927

8. AGE: Years: 20 Months: 8 Days: 20 If less than one day: hrs. min.

9. Birthplace: Pungoteague Accomack Va.
(Town, county, and state)

10. Usual occupation: Truck driver

11. Industry or business:

FATHER
12. Name: Wilbert Clarke
13. Birthplace: Virginia

MOTHER
14. Maiden name: Virginia F. Bourchel
15. Birthplace: N.Y.

16. Informant: Wilbert Clarke
Address: Pungoteague Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 3, 1947 (month) (day) (year)
Cemetery or crematory: Mechanics
Location: Pungoteague Va
18. Funeral director: Walter M. Case Jr.
Address: Pungoteague Va

19. Dec. 3 1947 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 29th 1947, at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 30th 1947, to 19; and that I last saw h[illegible] alive on Nov 30th 1947

Immediate cause of death	DURATION
Hemorrhage	
Due to Gun shot wound through chest	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide? Homicide Date of 11/29/47
Where did injury occur? 3½ mi. Pocomoke Worcester Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Bradley's Cottages
Means of injury: gun shot Injured at work? No

23. SIGNATURE: N. E. Castorena M.D.
M. D. or other
Address: Fremont City Md Date signed: 11/30/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect or incomplete is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

10495
10495

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 351

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Worcester
City or town Snow Hill Rural #1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Snow Hill Rural #1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war No

3. (a) FULL NAME Iona Iona S. Eckersley
3. (b) Social Security Number None

4. Sex Female
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife James R. Eckersley Sr.
6.(c) If alive, give age 61 years
7. Birth date of deceased (mo., day, yr.) May 9 - 1882
8. AGE: Years 65 Months 6 Days 9 If less than one day ... hrs. ... min.
9. Birthplace Snow Hill Worcester Md (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home
FATHER 12. Name William Tilghman
13. Birthplace Maryland
MOTHER 14. Maiden name Josephine Hewlett
15. Birthplace Maryland
16. Informant Mr. James R. Eckersley Sr.
Address Snow Hill Md Rural #1
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 21/47 (month) (day) (year)
Cemetery or crematory Whatcoat
Location Snow Hill, Md
19. Funeral director Elroy E. Dryden
Address Snow Hill, Md
19. 11/20 1947 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18 1947 at 9:35 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 19... to Nov 18 1947
and that I last saw her alive on Nov 18 1947

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to Arterio-sclerosis	unknown
Due to Diabetes Mellitus	unknown
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE Paul Cohen M.D. (M. D. or other)
Address Snow Hill Date signed 11/20/47

VS A15 9-45-15M

10496

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:
County: Worcester
City or town: Rural Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? ✓
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Rural Pocomoke Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Charles Graham

3.(b) Social Security Number ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: D K.
6.(c) If alive, give age: D K years

7. Birth date of deceased (mo., day, yr.): D K 1892

8. AGE: Years: 55 | Months: — | Days: — | If less than one day: ...hrs. ...min.

9. Birthplace: Ga. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: D K.
13. Birthplace: D K

MOTHER
14. Maiden name: D K
15. Birthplace: D K

16. Informant: Edgar Allen Hall
Address: Pocomoke City Md RR

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 16, 1947 (month) (day) (year)
Cemetery or crematory: Unionville Cemetery
Location: Rural Pocomoke City Md.

18. Funeral director: Henry L. Watson
Address: Pocomoke City Md.

19. Nov 14, 1947 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 8th 1947, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~Dec~~ Jan 1947, to death Nov 1947
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
(a) 1 Hours (Coronary Thrombosis)	
Due to (b) (Probably accidental)	
Due to (c)	
Due to (d)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Probably Date of ...
Where did injury occur? (Town) Pocomoke (City or town) Worcester Co. (County) Md. (State)
Injured at home, farm, industry, public place (where?) ✓
Means of injury: Fall Injured at work?

23. SIGNATURE: N. E. Justis M.D.
M. D. or other
Address: Pocomoke City Md. Date signed: 11/14/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

10497

CERTIFICATE OF DEATH

Reg. Diat. No. 350

1. PLACE OF DEATH:
County Worcester
City or town Pocomoke City Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all his life
Hospital, institution, or street address where death occurred: 506 Young St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Worcester
City or town Pocomoke City Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 506 Young
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Collier James Henry

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C.	Widowed

6.(b) Name of husband or wife Violet Collier
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 16th 1874

8. AGE: Years	Months	Days	If less than one day
73	6	2	hrs. ..... min.

9. Birthplace Pocomoke City Md
(Town, county, and state)
10. Usual occupation Janitor
11. Industry or business Store
FATHER 12. Name Collier James Henry
13. Birthplace D.K.
MOTHER 14. Maiden name Lyza Ford
15. Birthplace D.K.
16. Informant Collier James Francis
Address Pocomoke City Md
17. Burial (Burial, cremation, or removal) Which? Date thereof Nov. 22, 1947 (month) (day) (year)
Cemetery or crematory Hall's Hill
Location Pocomoke City Md R.F.D.
18. Funeral director Harvey Bradshaw
Address Pocomoke City Md
19. Nov 21, 1947 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18th 1947, at 9 P.M.

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from Months 1944, to Nov 16 1947
and that I last saw h.. alive on Nov 16 1947

	DURATION
Immediate cause of death	
Due to Cardio-Vascular disease	3 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE N. E. Castorino M.D.
M. D. or other
Address Pocomoke City Md Date signed 11/20/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct name and age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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10498

CERTIFICATE OF DEATH

Reg. Dist. No. 357

1. PLACE OF DEATH:
County: Worcester
City or town: Snow Hill Rural #2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 years 11 Mo. 12 Days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill Rural #2
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Mabel G Hudson

3.(b) Social Security Number: Dulany Camp La Fruitland, Md

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 26 - 1913

8. AGE:

Years	Months	Days	If less than one day
33	11	12	hrs. min.

9. Birthplace: Snow Hill Worcester, Md
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home

FATHER
12. Name: Charles Hudson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Harriet Price
15. Birthplace: Maryland

16. Informant: Charles Hudson
Address: Snow Hill, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 11/47 (month) (day) (year)
Cemetery or crematory: Friendship
Location: Snow Hill, Md Rural #2

18. Funeral director: LeRoy O. Smith
Address: Snow Hill, Md.

19. 11/11/47 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 8 1947 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 8 1947 to Nov. 8 1947 and that I last saw her alive on Nov. 8 1947

Immediate cause of death	DURATION
(a) Acute Mesenteric Thrombosis	20 Hours
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert L. LeMar, MD M. D. or other
Address: Snow Hill Date signed 11-11-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If necessary, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

10518

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:

County Worcester.

City or town West Ocean City (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Worcester.

City or town West Ocean City. (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME James Corbet Melvin

3. (b) Social Security Number

4. Sex: Male | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Divorced.

6.(b) Name of husband or wife Lizzy Melvin

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) June 8, 1897

8. AGE: Years 50 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Chincoteague Va. (Town, county, and state)

10. Usual occupation Merchant.

11. Industry or business

FATHER 12. Name William E. Melvin.

13. Birthplace Delaware,

MOTHER 14. Maiden name Ella Robbins,

15. Birthplace N. J.

16. Informant Mrs. Lizzy Melvin

Address 231 Buckley St. Bristol, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/30/47 (month) (day) (year)

Cemetery or crematory

Location Chincoteague Va.

18. Funeral director (Anna A. Bunting)

Address Berlin, Md.

19. Walter Clark Chincoteague

11-30-47 (Date rec'd by registrar) 19 Helen I. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1947, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 26 1947, to Nov 27 1947

and that I last saw him alive on Nov 27 1947

Immediate cause of death Coronary Thrombosis. DURATION 7 hours

Due to Cardiovascular disease ?

Due to

Other conditions Peptic ulcer? (Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE F. J. Townsend, Jr. M. D. or other

Address Ocean City Md Date signed Nov 28, 47.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

10493

CERTIFICATE OF DEATH

Reg. Dist. No. 353

1. PLACE OF DEATH:

County: Worcester

City or town: Bishop Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Worcester

City or town: Bishop Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Hennie Showell Price

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	colored	married

6.(b) Name of husband or wife: Alonzo Price

6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): Possibly 1890

8. AGE: Years	Months	Days	If less than one day
app. 57			hrs. min.

9. Birthplace: Showell, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Benjamin Showell

13. Birthplace: Md.

MOTHER 14. Maiden name: Eliza Showell

15. Birthplace: Md.

16. Informant: Alonzo Price

Address: Bishop, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-4-47 (month) (day) (year)

Cemetery or crematory: Showell cemetery

Location: Showell Md.

18. Funeral director: Henry S. Watson

Address: Pocomoke City, Md.

19. 11/3 47 Mrs. Ray Bergey (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 1 19 47, at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 10-30 19 47, to 11-1 19 47

and that I last saw her alive on 10-30 19 47

Immediate cause of death	DURATION
Cerebral apoplexy	
Due to: Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Clifford E. Talbott M. D. ~~or other~~

Address: Berlin Md. Date signed

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 10500

CERTIFICATE OF DEATH

Reg. Diat. No. 355

1. PLACE OF DEATH:

County: Worcester

City or town: Berlin

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 82 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Worcester

City or town: Berlin.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: SADIE CATHERINE RICHARDSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6.(b) Name of husband or wife: JOHN RICHARDSON

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): JAN. 15, 1866

8. AGE:

Years	Months	Days	If less than one day
81	10	11	hrs. min.

9. Birthplace: Berlin Worc. Co. Md.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: JAMES S. WILLIAMS.

13. Birthplace: BERLIN, MD.

MOTHER

14. Maiden name: MARGARET A. DAVIDSON

15. Birthplace: BERLIN, MD.

16. Informant: MR. RALPH RICHARDSON

Address: BERLIN MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 11/9/47 (month) (day) (year)

Cemetery or crematory: EVERGREEN

Location: BERLIN MD.

18. Funeral director: Annie A. Burbage

Address: BERLIN MD

19. 11-9-47 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 6 1947 at 8.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw her alive on ..... 19.....

Immediate cause of death: Chronic Nephritis

Myocarditis

Due to: Arteriosclerosis, Generalized & Dementia — DURATION: 6 yrs

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: Leonard Ashburn M.D. M. D. or other

Address: Berlin, Md. Date signed: 11-12-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

10501 Reg. Dist. No. 350

1. PLACE OF DEATH:
County Worcester
City or town Good Will (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 34 years
Hospital, institution, or street address where death occurred —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Worcester
City or town Pocomoke City Md Rural (If outside city or town limits, write RURAL and give nearest town)
Street No. — (If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Wm Thomas Shay
3. (b) Social Security Number —

4. Sex M.
5. Color or race W
6.(a) Single, married, widowed, or divorced widower
6.(b) Name of husband or wife Sollie Francis Shay
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Feb 2nd 1873
8. AGE: Years 74 Months 9 Days 15 If less than one day ... hrs. ... min.
9. Birthplace Makemie Park Accomac Co (Town, county, and state)
10. Usual occupation Farming
11. Industry or business
FATHER 12. Name Wm Shay
13. Birthplace Accomac Co Va
MOTHER 14. Maiden name Susan Coulbourne
15. Birthplace Accomac Co Va
16. Informant Edgar Winfield Shay
Address Pocomoke City Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 20-1947 (month) (day) (year)
Cemetery or crematory Holl Hill Baptist
Location Rural Pocomoke Md
18. Funeral director Henry H. Watson
Address Pocomoke Md
19. Nov. 19 1947 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17th 1947 at 12 P M
21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Nov 17th 1947, to ... 19...
and that I last saw h... alive on ... 19...

		DURATION
Immediate cause of death	Likely Asthmatic Attack	
	Had had very frequent bad attacks	
Due to	Left Ventricular Failure	years
Due to		
Other conditions (Include pregnancy within 3 months of death)	Prostatic trouble	years

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. C. Pastorius MD M. D. or other
Address Pocomoke City Md Date signed 11/17/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10502

93d

Reg. Dist. No. 355

1. PLACE OF DEATH:
County: Worcester
City or town: Berlin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 YEARS
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Worcester
City or town: Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME J. RUSSELL VERBRYCKE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widower

6.(b) Name of husband or wife: Elizabeth Verbrycke
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): NOV. 5, 1860

8. AGE:

Years	Months	Days	If less than one day
87	0	5	hrs. min.

9. Birthplace: NEW BRUNSWICK, N. J.
(Town, county, and state)

10. Usual occupation: MINISTER

11. Industry or business

FATHER
12. Name: JOHN VERBRYCKE
13. Birthplace: NEW BRUNSWICK, N.J.

MOTHER
14. Maiden name: HANNAH E. SMITH.
15. Birthplace: NEW BRUNSWICK N.J.

16. Informant: DR. J. RUSSELL VERBRYCKE JR
Address: PARKWOOD MED. BLDG. WASHINGTON D.C.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 11/12/47 (month) (day) (year)
Cemetery or crematory: BUCKINGHAM
Location: BERLIN, MD.

18. Funeral director: ANNA A. BURBAGE
Address: BERLIN, MD

19. 11-12 1947 (Date rec'd by registrar) Helen F. Hayward (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 Nov 1947 at 5:22 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1947 to 10 Nov 1947 and that I last saw him alive on 10 Nov 1947

Immediate cause of death	DURATION
Hypostatic Pneumonia	
Due to: Chronic degenerative myocarditis	2 mo.
Due to: Senility	
Other conditions: Senescent atherosclerosis & Calcareous Dementia.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Herman A. Babbitt M.D. (M. D. or other)
Address: Berlin, Md. Date signed: 11 Nov 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

10503

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:
County: Worcester
City or town: Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 80 years.
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Harry James Whyte

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Mrs Belle Whyte
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 24, 1867

8. AGE: Years	Months	Days	If less than one day
80	2	20	..... hrs. ..... min.

9. Birthplace: R.F.D. Pocomoke Somerset Md.
(Town, county, and state)

10. Usual occupation: painter

11. Industry or business

FATHER — 12. Name: Harry James Whyte
FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Olivia Whittington
MOTHER — 15. Birthplace: Maryland

16. Informant: Miss Madzie Cluff
Address: Pocomoke

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 17-1947 (month) (day) (year)
Cemetery or crematory: St Mary Episcopal
Location: Pocomoke Md.

18. Funeral director: Henry F. Watson
Address: Pocomoke Md.

19. Nov. 17 1947 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 14th 1947 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1st 1947 to Nov 15th 1947
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
(a) Probably Coronary Embolism	Instantaneous
Due to:	
Due to:	
Other conditions: Wearied Jig over 2 years	

(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Dr. Frederick Tevis M.D.
Address: Pocomoke Md. Date signed 11/16/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M